STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175245	A. BUILDING _____ B. WING _____	03/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - EDWARDSVILLE	751 BLAKE ST. EDWARDSVILLE, KS 66111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and Complaint Investigation #KS00073272.	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified	F 225		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175245	A. BUILDING _____ B. WING _____	03/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - EDWARDSVILLE	751 BLAKE ST. EDWARDSVILLE, KS 66111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 1 appropriate corrective action must be taken. This Requirement is not met as evidenced by: The facility identified a census of 92 residents. The sample size included 15 residents. Based on observation, record review, and interview the facility failed to investigate and report to the state agency for 1 (#36) resident of 2 sampled for personal property. Finding included: - The quarterly Minimum Data Set (MDS) dated 2/28/14 revealed the resident was not assessed for cognition. The quarterly MDS dated 12/6/13 revealed the resident had a Brief Interview for Mental Status score of 15 which indicated the resident was cognitively intact. On 3/4/14 at 12:52 P.M. the resident stated he/she had a billfold with money stolen. He/she had reported the lost money and billfold to the social service employee. On 3/10/14 at 12:17 P.M. the resident was sat at the dining room table. Direct care staff O assisted the resident to his/her to room. On 3/11/14 at 8:59 A.M. direct care staff P stated the resident had a billfold stolen. The billfold was found in another resident's room, but could not remember the exact date. When the billfold was returned to the resident he/she reported $3.00 were missing. Direct care staff P stated he/she or the nurse would fill out a grievance report of missing items then turn it into the nursing supervisor or to the administrator.	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175245	A. BUILDING _____ B. WING _____	03/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - EDWARDSVILLE	751 BLAKE ST. EDWARDSVILLE, KS 66111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 2	F 225		

On 3/11/14 at 12:24 P.M. license staff H stated he/she had counted $8.00 in the resident's billfold a few days before the resident's billfold was missing. He/she worked the day the resident's billfold was missing. The resident notified the Certified Nurse Aide (CNA) who notified license staff H. License staff H notified the administrator. The resident was glad to get the billfold back but was concerned about the missing money of $8.00.

On 3/11/14 at 9:30 A.M. administrative nursing staff D stated he/she would expect the staff to notify him/herself, social services or the administrator if a resident had personal property missing. Staff were expected to notify them by phone if they were not in the building.

On 3/11/14 at 12:31 P.M. social service staff HH stated there was no grievance filed for this resident for a missing billfold. He/she stated when a grievance was written it would be given to social services who followed up by doing an investigation. The facility would contact the police or the state agency per decision of the administrator.

On 3/11/14 at 12:36 P.M. Administrative staff A stated if the resident filled out a grievance report and the staff gave it to the social service department to investigate. He/she would report to the police if missing items were above $50.00 and to the state agency a legitimate allegation that a resident had money stolen from them.

The facility Investigation and Reporting of Alleged Violations of Federal and State Laws Involving Mistreatment, Neglect, Abuse, Injuries of Unknown Source and Misappropriation of Resident's Property dated 7/1/08 revealed the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175245	A. BUILDING _____ B. WING _____	03/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - EDWARDSVILLE	751 BLAKE ST. EDWARDSVILLE, KS 66111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 3 facility would prevent the occurrence of resident's misappropriation of resident's property and reported immediately to the executive director of the facility to be reported to the state agency in accordance with existing state law. The facility investigated such alleged violations. The facility failed to fill out a grievance, investigate and report to the state agency as required an allegation of missing money.	F 225		
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This Requirement is not met as evidenced by: The facility identified a census of 92 residents. The facility reported they employed 9 housekeeping and laundry employees through a contracted company. Based on record review and interview, the facility failed to ensure contracted staff received training to identify and report abuse. Findings included: - Record review on 3/11/14 revealed the policy for investigating and reporting alleged violations of federal and state laws involving mistreatment, neglect, abuse, and injuries of an unknown source, and misappropriation of resident's property provided by the facility last revised on 7/1/08 revealed the facility would take appropriate steps to prevent the occurrence of abuse and neglect to the residents.	F 226		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175245	A. BUILDING _____ B. WING _____	03/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - EDWARDSVILLE	751 BLAKE ST. EDWARDSVILLE, KS 66111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 4 On 3/11/14 at 9:55 A.M. with housekeeping staff Y, stated he/she did not receive education on what abuse was or how to report abuse upon hire, and had not attended any inservices on abuse. An interview on 3/11/14 at 11:22 A.M. with housekeeping staff X revealed he/she worked for a company contracted by the facility for housekeeping and laundry. Upon hire staff were given hand outs and watched videos on recognizing abuse and reporting abuse. He/she had read the handouts and watched the videos but was not aware if current staff received education on hire. He/she would not intervene with abuse if it was witnessed and would walk away and report it to the charge nurse. An interview on 3/11/14 at 11:00 A.M. with administrative nursing staff D revealed the facility did not provide abuse training for the housekeeping and laundry staff as they were employed by a separate company, he/she was unaware of what education or training the contracted company provided their employees, and expected housekeeping and laundry staff to identify and report abuse the same as facility staff did. Interview on 3/11/14 at 11:16 A.M. with licensed nursing staff J revealed he/she provided new hires with abuse and neglect information upon hire but had no knowledge if housekeeping and laundry staff recieved training on recognizing and reporting abuse as they were employed by a different company. During an interview on 3/11/14 at 11:53 A.M. administrative staff A revealed he/she was	F 226		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175245	A. BUILDING _____ B. WING _____	03/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - EDWARDSVILLE	751 BLAKE ST. EDWARDSVILLE, KS 66111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 5 unaware what training housekeeping and laundry employees received on abuse recognition and reporting, they were included in on the spot training that happened periodically, were not required to attend annual training through the facility for abuse, and he/she expected all staff to recognize and report abuse. The facility failed to ensure contracted staff received training on recognizing and reporting abuse and neglect.	F 226		
F 258 SS=D	483.15(h)(7) MAINTENANCE OF COMFORTABLE SOUND LEVELS The facility must provide for the maintenance of comfortable sound levels. This Requirement is not met as evidenced by: The facility identified a census of 92 residents. The sample included 15 residents. Based on observation and interview the facility failed to provide acceptable noise levels for residents. Findings included: - On 3-4-14 at 12:57 P.M. confidential resident interview stated the carts were noisy at night in the hall and disturbed his/her sleep. On 3-4-14 at 1:21 P.M. an unsampled resident stated the machine staff used to clean the hall early in the morning was noisy. Observation on 3-3-14 at 3:16 P.M. housekeeping/laundry staff X rolled 2 carts from one hall to another hall, the carts were very loud and disrupted conversation due to the noise level.	F 258		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175245	A. BUILDING _____ B. WING _____	03/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - EDWARDSVILLE	751 BLAKE ST. EDWARDSVILLE, KS 66111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 258	Continued From page 6 Observation on 3-3-14 at 3:24 P.M. revealed housekeeping/laundry staff X rolled 2 carts from one hall to another hall, the carts were loud and disrupted conversation due to the noise level. Observation on 3-10-14 at 2:21 P.M. revealed housekeeping/ laundry staff X rolled 2 carts from one hall to another, was loud and disrupted conversation due to the noise level. On 3-11-14 at 7:36 A.M. housekeeping/laundry staff X acknowledged the carts were noisy when he/she rolled them in the hall. The facility failed to provide a policy and procedure for noise level control. The facility failed to maintain comfortable noise levels for residents while providing housekeeping and laundry services.	F 258		
F 272 SS=E	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns;	F 272		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175245	A. BUILDING _____ B. WING _____	03/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - EDWARDSVILLE	751 BLAKE ST. EDWARDSVILLE, KS 66111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 7 Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This Requirement is not met as evidenced by: The facility identified a census of 92 residents. The sample included 15 residents. Based on observation, record review, and staff interview the facility failed to complete the Minimum Data Set 3.0 (MDS) and provide Care Area Assessments (CAA's) in a timely manner for 6 (#1, #23, #36, #64, #72, and #76) of the sampled residents. Findings included: - Record review of resident #1 revealed a Significant Change in Status MDS had an assessment reference date (ARD) of 7/11/13, and was completed on 7/25/13. The CAA's were not completed until 9/11/13.	F 272		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175245	A. BUILDING _____ B. WING _____	03/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - EDWARDSVILLE	751 BLAKE ST. EDWARDSVILLE, KS 66111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 8 Interview on 3/11/14 at 9:30 A.M. with administrative nursing staff D stated the facility was aware and were working on the timeliness of CAA completion. Observation on 3/11/14 at 7:43 A.M. the resident sat in a broda chair while out of bed. On 3/11/14 at 10:36 A.M. licensed nursing staff I stated he/she was responsible at this time for the completion of the MDS and CAA's, and knew these assessments were late. The revised policy and procedure for Resident Assessment Instrument (RAI) process dated 1/2011 provided by the facility stated the facility would adhere to all Center for Medicare and Medicaid Services (CMS) which included completion of the CAA's. The facility failed to ensure the comprehensive assessment included completion of the CAA within the resident Assessment User Manual timeframe for this resident with a significant change in status. - Record review of resident #72 revealed an annual MDS had an Assessment Refrence Date (ARD) of 9/13/13, and was completed on 9/27/13. The CAA's were not completed until 10/28/13. Interview on 3/11/14 at 9:30 A.M. with administrative nursing staff D stated the facility was aware and were working on the timeliness of CAA completion. Observation on 3/10/14 the resident wheeled him/her self down the hallway and stated he/she needs to use the restroom.	F 272		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175245	A. BUILDING _____ B. WING _____	03/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - EDWARDSVILLE	751 BLAKE ST. EDWARDSVILLE, KS 66111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 9 On 3/11/14 at 10:36 A.M. licensed nursing staff I stated he/she was responsible at this time for the completion of the MDS and CAA's, and knew these assessments were late. The revised policy and procedure for Resident Assessment Instrument (RAI) process dated 1/2011 provided by the facility stated the facility would adhere to all Center for Medicare and Medicaid Services (CMS) which included completion of the CAA's. The facility failed to ensure the comprehensive assessment included completion of the CAA within the Resident Assessment User Manual timeframe for this resident. - Review of the Annual Minimum Data Set (MDS) dated 11/29/13 for resident #64 revealed Section C: Cognitive Patterns was not completed. On 3/11/14 at 10:15 A.M. license staff I stated the resident refused to complete a Brief Interview for Mental Status (BIMS). He/she stated when a resident refused to complete a BIMS the computer system would not let him/her complete a staff assessment. Observation on 3/10/14 at 9:48 A.M.staff assisted the resident to the bathroom. On 3/11/14 at 10:58 A.M. administrative nursing staff E could not explain why the cognition part of the MDS was not completed. On 3/11/14 at 11:12 A.M. administrative nursing staff D stated he/she expected the MDS staff to	F 272		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175245	A. BUILDING _____ B. WING _____	03/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - EDWARDSVILLE	751 BLAKE ST. EDWARDSVILLE, KS 66111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 10 fill out the MDS assessments completely and on time. Section C was completed using either the BIMS or the staff assessment for mental status. On 3/11/14 at 11:20 A.M. license staff I stated the computer program for the MDS did not function correctly. The facility Policy Resident Assessment Instrument (RAI) Process dated January 2011 revealed the facility adhered to all Center for Medicare/Medicaid Services (CMS) which included coding the MDS. The corperate nurse consultant audited and reviewed the MDS's for accuracy and timeliness of completion. The facility failed to complete a comprehensive assessment for this resident. - The Quarterly MDS quarterly dated 2/28/14 for resident #36 section C: Cognitive Patterns was not completed. Observation on 3/10/14 at 12:17 P.M. the resident sat at the dining room table in a wheelchair. On 3/11/14 at 10:58 A.M. administrative nursing staff E stated he/she was sick when the 2/28/14 MDS was due for completion. He/she did not complete it in the computer. Administrative nursing staff E stated there were two other staff members able to complete the MDS by the end date. On 3/11/14 at 11:12 A.M. administrative nursing staff D stated he/she expected the MDS staff to fill out the MDS assessments completely and on time. Section C was completed using either the BIMS or the staff assessment for mental status.	F 272		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175245	A. BUILDING _____ B. WING _____	03/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - EDWARDSVILLE	751 BLAKE ST. EDWARDSVILLE, KS 66111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 11 On 3/11/14 at 11:20 A.M. license staff I stated the computer program for the MDS did not function correctly. The facilities Policy Resident Assessment Instrument (RAI) Process dated January 2011 revealed the facility adhered to all Center for Medicare/Medicaid Services (CMS) which included coding the MDS. The corporate nurse consultant audited and reviewed the MDS's for accuracy and timeliness of completion. The facility failed to conduct a comprehensive assessment of this resident. - Record review of resident #23 revealed an annual Minimum Data Set 3.0 (MDS) with an Assessment Reference Date (ARD) of 8/16/13. The Care Area Assessments (CAA)'s for the triggered areas were not completed until 9/14/13. On 3/11/14 at 10:36 A.M. licensed nursing staff I stated he/she was responsible at this time for the completion of the MDS and CAA's, and knew the CAA assessments were late. Observation on 3/4/14 at 1:35 P.M. the resident received scheduled eye drops. Interview on 3/11/14 at 9:30 A.M. with administrative nursing staff D stated the facility was working on the timeliness of CAA completion. The undated policy for resident assessment instrument process provided by the facility	F 272		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175245	A. BUILDING _____ B. WING _____	03/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - EDWARDSVILLE	751 BLAKE ST. EDWARDSVILLE, KS 66111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 12 revealed the facility adhered to all Center for Medicare and Medicaid Services regulations for MDS and CAA completion. The facility failed to complete a comprehensive assessment in a timely manner for this resident. - Record review of resident #76 revealed an admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/27/13. The Care Area Assessments (CAA)'s were not completed until 9/16/13. Observation on 3/10/14 at 3:10 P.M. the resident greeted staff cheerfully. On 3/11/14 at 10:36 A.M. licensed nursing staff I stated he/she was responsible at this time for the completion of the MDS and CAA's, and knew that the CAA assessments were late. Interview on 3/11/14 at 9:30 A.M. with administrative nursing staff D stated the facility was working on the timeliness of CAA completion. The undated policy for resident assessment instrument process provided by the facility revealed the facility adhered to all Center for Medicare and Medicaid Services regulations for MDS and CAA completion. The facility failed to complete a comprehensive assessment in a timely manner for this resident.	F 272		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175245	A. BUILDING _____ B. WING _____	03/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - EDWARDSVILLE	751 BLAKE ST. EDWARDSVILLE, KS 66111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 13 comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This Requirement is not met as evidenced by: The facility identified a census of 92 residents. The sample included 15 residents. Based on observation, interview, and record review the facility failed to develop a comprehensive care plan to include nutrition and plate guard for 2 of 15 resident's reviewed for care plans. (#94, #33) Findings included: - Resident #94's quarterly Minimum Data Set 3.0 Assessment (MDS) dated 12-24-13, documented the resident's Brief Interview for Mental Status score (BIMS) was 15, which indicated the resident had intact cognition. The resident was independent with activities of daily living (ADLs) and received dialysis (the artificial process of eliminating waste and unwanted fluid from the blood) services.	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175245	A. BUILDING _____ B. WING _____	03/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - EDWARDSVILLE	751 BLAKE ST. EDWARDSVILLE, KS 66111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 14	F 279		

The Nutrition Care Area Assessment (CAA) dated 7-13-13 documented the resident had obesity, diabetes mellitus (when the body cannot use glucose, there's not enough insulin made or the body cannot respond to the insulin) and denied any nutritional/diet issues.

The 2-14-14 care plan documented the resident had altered nutrition intake related to his/her renal failure (inability of the kidneys to excrete waste, concentrate urine and conserve electrolytes) congestive heart failure (a condition when the heart output is low and the body becomes congested with fluid), and diabetes mellitus. Interventions included dialysis treatment for the resident's renal failure, monitor laboratory data, monitor the resident's meal consumption, monitor weights, and follow the recommended fluid intake from the dialysis dietician.

On 2-14-14 the facility consultant dietician documented he/she spoke to the dialysis registered dietician (RD) who informed the dietician the resident was drinking excess fluid, came to dialysis with a fast food restarant cup, should avoid "fast food" and wanted the resident to follow a 2 gram (gm) low sodium diet along with limiting fluid intake. The dietician documented dialysis gave the resident a 24 ounce (oz) bottle and asked the resident to limit his/her intake to 48 oz per day. The dialysis dietician asked the resident to consume less salty food and requested the resident's sack lunch contain low sodium meats and crackers. Staff would encourage the resident's compliance with his/her diet and monitor.

On 2-27-14 at 5:43 P.M. the behavior note documented the resident was not following the food and fluid intake instructions. Staff attempted

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175245	A. BUILDING _____ B. WING _____	03/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - EDWARDSVILLE	751 BLAKE ST. EDWARDSVILLE, KS 66111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 15	F 279		

to educate the resident about using measured cups to decrease his/her fluid intake, and eat less carry out and fast food. According to the note, the resident acknowledged the education.

On 3-10-14 at 9:21 A.M. the interdisciplinary progress note documented the resident had a habit of going off his/her diet, ate and drank things that were not good for him/her since he/she received dialysis, and staff educated the resident over and over, but the resident continued to make poor food choices at times.

On 3-11-14 at 8:25 A.M. observation revealed the resident in his/her bed and the resident stated he/she was not going to eat breakfast but wanted to stay in bed.

On 3-11-14 at 12:10 P.M. observation revealed the resident ate his/her lunch independently that included a taco salad without chips and a bottle of pop.

On 3-10-14 at 9:00 A.M. the resident stated he/she was going to dialysis. The resident stated he/she was on a fluid restriction and referred to a bottle on his/her dresser stating he/she could have a bottle of fluid at each meal and tried to follow his/her dietary restrictions.

On 3-10-14 at approximately 1:30 P.M. dietary staff DD stated dialysis recommended the resident receive a low sodium diet and restricted fluid intake. Dietary staff DD stated the facility did not offer therapeutic diets, but provided low sodium turkey sandwiches and low sodium chips

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175245	A. BUILDING _____ B. WING _____	03/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - EDWARDSVILLE	751 BLAKE ST. EDWARDSVILLE, KS 66111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 16 in a sack lunch for the resident when he/she went to dialysis three times weekly. On 3-10-14 at 3:57 P.M. direct care staff Rstated he/she was not aware of any dietary/fluid recommendations for the resident. He/she referred to his/her care attendant sheet and it lacked any reference to monitor the resident's dietary/fluid intake. On 3-10-14 at 3:50 P.M. licensed staff K stated dialysis educated the resident on fluid and diet recommendations however the facility did not provide therapeutic diets and it was the resident's choice. On 3-11-14 at 11:15 A.M. licensed nurse I stated dialysis worked with the resident regarding his/her diet and provided education with the resident regarding his/her fluid intake and diet. Licensed nurse I stated dialysis gave the resident a cup and instructed the resident how much fluid he/she could have and dietary staff assisted the resident with better choices when he/she went through the line at the facility for meals. He/she stated the facility did not offer therapeutic diets because the resident had a right to have what he/she wanted, but staff educated the resident on the choices he/she made. On 3-11-14 at 12:16 P.M. dietary staff EE stated he/she encouraged residents to make different dietary choices if needed. On 3-11-14 at approximately 1:00 P.M.	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175245	A. BUILDING _____ B. WING _____	03/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - EDWARDSVILLE	751 BLAKE ST. EDWARDSVILLE, KS 66111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 17	F 279		

administrative nurse D stated he/she would expect the care plan to include interventions from the recommendations the dialysis dietician asked the resident to follow regarding fluid and diet recommendations.

The facility revised policy and procedure for Resident Assessment Instrument (RAI) process dated 1/2011 adhered to all Center for Medicare and Medicaid Services (CMS) which included development of a comprehensive plan of care.

The facility failed to develop a comprehensive care plan to include fluid and dietary recommendations for this resident who received dialysis services.

- The quarterly Minimum Data Set 3.0 (MDS) dated 1/17/14 for resident #33 revealed the resident had upper extremity impairment on one side, and the resident required supervision while eating.

The care plan revised on 8/23/13 lacked evidence the resident used a plate guard during meals.

Record review on 3/11/14 revealed an order wrritten 3/16/2010 for the resident to use a plate guard during meals.

Observation on 3/4/14 at 11:50 A.M. revealed the resident used a plate guard on the left side of the plate, and the residents left arm was not used while eating and remained in sling.

On 3/10/14 at 12:08 P.M. the resident consumed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175245	A. BUILDING _____ B. WING _____	03/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - EDWARDSVILLE	751 BLAKE ST. EDWARDSVILLE, KS 66111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 18	F 279		

75 percent of his/her meal, and used a plate guard on the left side of the plate.

On 3/11/14 at 7:30 A.M. the resident used a plate guard on left side of the plate to assist with eating during breakfast.

Interview on 3/10/14 at 2:15 P.M. direct care staff Q stated the resident used a plate guard at meals.

On 3/11/14 at 8:01 A.M. licensed nursing staff L stated the resident used a plate guard at meals, and staff would add this to the care plan. All licensed nursing staff and administrative nursing staff E were responsible to update the care plans.

On 3/11/14 at 9:30 A.M. administrative nursing staff D stated if residents usedassistive devices, such as a plate guard, staff would list them on the care plan.

On 3/11/14 at 1:07 P.M. administrative nursing staff E stated licensed nursing staff or dietary staff DD updated the care plans for assistive devices that were used during dining.

On 3/11/14 at 1:10 P.M. dietary staff DD stated he/she did not know who updated the care plans for assistive devices used during dining.

The revised policy and procedure for Resident Assessment Instrument (RAI) process dated 1/2011 provided by the facility stated the facility would adhere to all Center for Medicare and Medicaid Services (CMS) which included development of a comprehensive plan of care.

The facility failed to develop a comprehensive care plan for assistive devices used during dining

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175245	A. BUILDING _____ B. WING _____	03/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - EDWARDSVILLE	751 BLAKE ST. EDWARDSVILLE, KS 66111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 19 to maintain maximum functioning for this physically impaired resident.	F 279		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175245	A. BUILDING _____ B. WING _____	03/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - EDWARDSVILLE	751 BLAKE ST. EDWARDSVILLE, KS 66111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 20	F 441		

This Requirement is not met as evidenced by:
The facility identified a census of 92 residents. Based on observation, record review,and staff interview, the facility failed to utilize precautions to minimize transmission of infection on 4 of 4 halls, and failed to transport clean laundry in a sanitary manner to residents of the facility.

Findings included:

- Observation on 3/5/14 at 3:45 P.M. housekeeping/laundry staff AA transported clean linens in a cart uncovered.

Interview on 3/5/14 at 4:15 P.M. with housekeeping/laundry staff AA revealed staff could cover the laundry when it was transported, his/her previous supervisor told him/her laundry did not have to always be covered since the linens were clean.

Interview on 3/5/14 at 4:16 P.M. with housekeeping/laundry staff X revealed laundry carts were always covered when transporting clean linens, no exception. Laundry staff were given training on transporting linens during orientation.

The facility failed to provide a policy for transporting linens.

The facility failed to distribute laundry in a sanitary manner.

- Observation on 3/10/14 at 1:58 P.M. housekeeping/laundry staff BB wore gloves to clean a resident's room.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175245	A. BUILDING _____ B. WING _____	03/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - EDWARDSVILLE	751 BLAKE ST. EDWARDSVILLE, KS 66111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 21 Review of the label on the disinfectant cleaner used by housekeeping/laundry staff BB during the room cleaning, revealed a bottle labeled A-456 11 disinfectant cleaner lacked information about the specific organisms it eliminated and contact time. Interview on 3/10/14 at 1:55 P.M. with housekeeping/laundry staff BB revealed he/she was not aware of the contact time for products used to clean rooms and did not know how to clean an isolation room. Interview on 3/10/14 at 2:20 P.M. with housekeeping/laundry staff X revealed contact times were not on the cleaning bottles on the housekeeping carts or on the bottles in the housekeeping closet, he/she had a book that had the information but he/she had not trained staff on the information. The policy for standard room cleaning dated 1/11/13 revealed the facility would ensure the complete and systematic daily cleaning and disinfection of each resident's room. The facility failed to utilize precautions to minimize transmission of infection.	F 441		